ARTICLE 3. SCOPE OF BENEFITS

2699.300. Minimum Scope of Benefits

(a) The basic scope of benefits offered by participating health plans to subscribers and infants shall include all of the benefits and services listed in this section. No other benefits shall be permitted to be offered by a participating health plan unless specifically provided for in the program contract with the participating health plan. The basic scope of benefits shall be as follows:

(1) Services required to be provided by a health care service plan approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations as amended on May 5, 1982 and redesignated on September 30, 1987.

(2) Durable medical equipment.

(3) Inpatient mental health benefits limited to ten (10) days in each calendar year.

(4) Emergency transportation.

(5) Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists for short-term therapy of acute conditions on an outpatient and inpatient basis.

(6) Health education services, including health education services relating to tobacco use and drug and alcohol abuse.

(7) Direct patient care nutrition services, including nutritional assessment.

(8) Medically necessary prescription drugs, including prenatal vitamins. Prescription drugs are limited to drugs approved by the federal Food and Drug Administration, generic equivalents approved as substitutable by the federal Food and Drug Administration, or drugs approved by the federal Food and Drug Administration as Treatment Investigational New Drugs.

(9) Plastic and reconstructive surgical services limited to the following:

(A) Surgery to correct a physical functional disorder resulting from a disease or congenital anomaly.

(B) Surgery to correct a physical functional disorder following an injury, or incidental to surgery which was or would have been covered pursuant to this section.

(C) Reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury, and breast prosthesis required incidental to the surgery.

(10) Non-experimental human organ transplants. Transplants other than corneal shall be subject to the following restrictions:

(A) Preoperative evaluation, surgery, and follow-up care shall be provided at centers that have been designated by the participating health plan as

having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.

(B) Patients shall be selected by the patient-selection committee of the designated centers and subject to prior authorization.

(C) Only one transplantation per organ-type per patient is covered. Replacement of a rejected organ will not be covered.

(D) Only anti-rejection drugs, biological products, and other procedures that have been established as safe and effective, and no longer investigational, are covered.

(b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(c) Nothing in this section shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Sections 12696.05 and 12698.30, Insurance Code.

2699.301. Excluded Benefits

(a) Plans offered under this program shall exclude the following benefits unless specifically provided for in the program contract with the participating health plan:

(1) Services which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

(A) It is appropriate and is provided in accordance with accepted medical standards in the state of California. and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

(B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

(C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

(D) The service or article has been demonstrated to be of significantly greater therapeutic value than other, less expensive, services or articles.

(2) Any services which are received prior to the enrollee's effective date of coverage, except as provided in Section 2699.303.

(3) Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily

living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

(4) Personal or comfort items, or a private room in a hospital unless medically necessary.

(5) Emergency facility services for nonemergency conditions.

(6) Those medical, surgical (including implants), or other health care procedures, services, drugs, or devices which are either:

(A) Services, products, drugs or devices which are experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(B) Outmoded or not efficacious.

(7) Transportation except as specified in Section 2699.300(a)(4).

(8) Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Section 2699.300(a)(9)(C).

(9) Sex change operations and reversal of sterilization.

(10) Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine preventative examination for minors, hearing aids, orthopedic shoes, and orthodontic appliances.

(11) Long-term care benefits including skilled nursing care, respite care, and hospice care are excluded except as a participating health plan shall determine they are less costly alternatives to the basic minimum benefits.

(12) Dental services, including dental treatment for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible.

(13) Residential treatment of chemical dependency or institutional treatment for rehabilitation related to chemical dependency.

(14) Treatment of obesity by medical or surgical means.

(15) Cosmetic surgery, including treatment for complications of cosmetic surgery, except as specifically provided in Section 2699.300(a)(9).

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

2699.302. Pre-Existing Conditions Exclusion and Postenrollment Waiting Period.

Subscribers and infants shall not be subject to any pre-existing condition exclusion period or postenrollment waiting period.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12696.05, Insurance Code.

2699.303. Services Received Prior to Enrollment

(a) Subscribers may be reimbursed up to a total of one hundred and twenty-five dollars ($125.00) per subscriber for pregnancy-related medically necessary services, including but not limited to pregnancy test and initial prenatal visit, received in the time period beginning forty (40) days prior to the date a complete application is received by the program and ending on the beginning date of coverage.

(b) Requests for payment pursuant to this section shall be submitted by the subscriber within ninety (90) days of the date service was provided and shall include the following information:

(1) An original bill which includes the name, and business address of the medical doctor, doctor of osteopathy, registered nurse, pharmacist or physician's assistant, or laboratory providing service,

(2) Name, address, date of birth and social security number (not mandatory) of the subscriber for whom services were provided,

(3) date service was provided,

(4) type of service provided,

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.25, Insurance Code.

2699.304. Order of Benefit Determination

The coverage of this program shall not duplicate and shall pay secondary to any other valid and collectible medical coverage.

NOTE: Authority cited: Section 12696.05, Insurance Code. Reference: Section 12698.06, Insurance Code.

Attachment B

Coopers & Lybrand

human resource advisory group

333 Market Street
San Francisco, CA 94105

telephone (415) 957-3000
facsimile (415) 957-3457

memorandum

to: **Sandra Shewry**
from: **Leslie Peters, FSA, MAAA**

date: **March 4, 1998**
subject: **AIM Benefit Package**

Per your request, we have analyzed the AIM benefits package for benchmark equivalence to the PERS plan. Overall, the AIM benefits are estimated to be 5% higher than the PERS benchmark HMO coverage.

If you have any questions about this benefit comparison, please call me at 415-957-3314.

2699.6713 Enrollee Share of Cost for Dental Benefits

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), "Diagnostic and Preventive Benefits."

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), "Restorative Dentistry," with the following exceptions:

(A) Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):

1. $5 per surface

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:

A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Soft tissue impaction -- No copayment.

2. Bony impaction -- $5 copayment per tooth.

(B) Root recovery as a separate procedure -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), "Endodontics", with the following exceptions:

(A) Root canal therapy is subject to copayments as follows:

1. $5 per canal

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of $5 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), "Periodontics", with the following exceptions:

(A) Osseous or muco-gingival surgery is subject to a copayment of $5 per quadrant.

(B) Gingivectomy is not subject to a copayment by quadrant or by tooth.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), "Crowns and Fixed Bridges", with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of $5.

(B) Pontics: Tru-pontic type; cast (sanitary); and porcelain baked with metal; are each subject to a copayment of $5. No copayment shall be charged for pontics made of plastic processed to gold.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), "Removable Prosthetics", with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture --$5.

2. Complete mandibular denture -- $5.

3. Partial acrylic upper or lower denture with clasps--$5.

4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -$5.

5. Removable unilateral partial denture -- $5.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline -- No copayment.

2. Laboratory reline --$5.

(C) Denture duplication-- $5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), "Orthodontia."

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), "Other".

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist, the copayment is $5.

(b) A fee of $5 shall be charged for failure to cancel an appointment with 24 hours prior notification.

(c) No deductibles shall be charged to subscribers for dental benefits.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6715 Waiting Periods for Receipt of Specified Benefits

Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6717 Scope of Vision Benefits

(a) The basic scope of benefits offered by a participating vision plan as a vision benefit plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6719. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows: